



ILLINOIS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

**WAIVING ANNUITANT GROUP INSURANCE COVERAGE  
NOTIFICATION AND ELECTION FORM**

In accordance with Public Act 93-553, this Notification and Election Form is provided to State of Illinois Retirement Systems Annuitants to inform them of the consequences of electing to participate in the State Employees Group Insurance Program as a *Dependent*, and the conditions and procedures for re-enrolling at a later time as an eligible *Member*. By completing this waiver and signing below, a person eligible to participate in the Group Insurance Program as an Annuitant, can elect to waive health, dental and vision Group Insurance coverage, and instead participate as a dependent of their spouse.

<b>Dependent Name:</b> _____
<b>Dependent SSN:</b> _____
<b>Daytime Phone #:</b> _____

<b>Spouse Name:</b> _____
<b>Spouse SSN:</b> _____
<b>Daytime Phone #:</b> _____

**I fully understand and certify to the following:**

1. In electing to participate in the health plan as a dependent of my eligible Spouse, I acknowledge that I am waiving health, dental and vision coverage as an Annuitant.
2. I will be enrolled as an Annuitant with Basic Life insurance coverage. If I currently have optional life coverage, I have the option of continuing that coverage. Statement of Health approval will be required to obtain additional optional life insurance coverage.
3. I cannot be enrolled in Spouse Life coverage as a dependent of my eligible spouse.
4. Re-enrollment in the health, dental and vision Program as an eligible Member can be done only during the annual Benefit Choice period (May 1-31 of each year) or within 60 days of a qualifying Change in Status. If I wish to re-enroll, I must contact my Group Insurance Representative to complete and sign the Initial Enrollment form (CMS-310), and submit the required back-up documentation.
5. I must provide a copy of my marriage certificate to my Group Insurance Representative.

**Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>GIR/P USE ONLY</b>	<b>Effective date Dependent is/was added to Spouse's H/D/V plan:</b> _____
	<b>Effective Date of Dependent Annuity:</b> _____
	<b>Type Enrollee Code</b> _____ <b>Part-time Percentage</b> _____ % <b>Basic Life Units</b> _____
	<b>Comments:</b> _____
	<b>Group Insurance Representative Signature/Date</b> _____ <b>Phone #</b> _____
	<b>Agency Name</b> _____ <b>Organizational Processing Code</b> _____